Meaningful Use Workgroup
Draft Transcript
March 8, 2011

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good afternoon, everybody and welcome to the Meaningful Use Workgroup. This is a Federal Advisory Committee, so there will be opportunity at the end of the meeting for the public to make comment and a reminder for committee members to please identify yourselves when speaking.

A quick roll call, Paul Tang.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Christine Bechtel.

Christine Bechtel – National Partnership for Women & Families – VP
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Neil Calman.

Neil Calman – Institute for Family Health – President & Cofounder
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Art Davidson?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Lansky?

David Lansky – Pacific Business Group on Health – President & CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Deven McGraw? Charlene Underwood?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Latanya Sweeney? Michael Barr? He was on. Jim Figge?

Jim Figge – NY State DoH – Medical Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Marty Fattig?

Marty Fattig – Nemaha County Hospital – CEO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Judy Murphy? Joe Francis? Bob Anthony, Robert Anthony?

Robert Anthony – CMS – Health Insurance Specialist
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Josh Seidman?

Josh Seidman – ONC
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Did I leave anyone off? Okay, I'll turn it over to Dr. Tang.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good morning, thank you, Judy. Thanks, everyone, for joining. We have two calls before the next face-to-face in April and, as you know the request for comments closed on February the 25th, so, merely short of two weeks ago. So, the ONC staff has been busily, under Josh, trying to compile all the information. I think there were just short of 500 comments. They're categorizing and seeing where it matches up to our draft criteria and additional questions we had and in just a moment Josh will give us an update on that, but what we thought we would do is hear a little bit on where we are there. Hopefully, there will be some time if they get far enough along at ONC staff to present some high level questions for us to start discussion on our March 22nd call in preparation for our April 5th face-to-face.

The second part of this morning's conversation is on additional hearings, in particular, as we all know specialists is still a group that we haven't adequately addressed yet. We certainly have a starting place on stage one, but how can we involve them more in the future stages. So, we thought we would hear more from specialists and part of our brainstorming today is sort of what areas to probe. We did have a hearing before our stage one final recommendation.

The other thing is we'd love to hear more experience from the field. There are something like 21,000 registrants for meaningful use. That's just a registration, that doesn't mean they'll all commit to any kind of early submission, but we may get some early indications of the missions, if any, by our next talk. Well, I guess it wouldn't be submissions yet, but some early experience and also from the field, in the RECs and some work that the Beacon communities might be doing. A topic that has come up to the office is regards imaging and imaging specialists like radiologists. We would include those as part of the specialist hearing. We'll conclude this call, like we do all calls, with public comment.

Any other additions to the agenda?

Judy Murphy – Aurora Health Care – Vice President of Applications
Paul, I just wanted to let you know that I joined.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thanks, Judy.

Deven McGraw – Center for Democracy & Technology – Director
Likewise, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Hi, Deven.

Joseph Francis – Department of Veterans Affairs – Associate Director, Health Services Research
Joe Francis with VA.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
All right, a big group. If there are no other agenda items, why don't we start with—is Josh on the line yet?

Josh Seidman – ONC
I am.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, great. Why don't you go ahead?

Josh Seidman – ONC
Thank you. We are busy at work. We have 422 comment submissions and I like to use the phrase comment submissions because, of course, every submission has many comments so we are processing the thousands of comments that come along with those 422 submissions. as Paul said, we will by the next call be able to talk about some very kind of high level feedback, but we won't have yet prepared the, kind of the documentation that will help to guide discussion. Our plan is by a week before the April 5th meeting, so that puts us at March 29th, to have for you a full analysis of all of the comments that came in and what we will present is kind of an overview document and then, basically an objective by objective presentation of what comments came in.

Now, in some cases we will actually cluster those objectives, so we may have some of the foundational data items like vital signs and smoking status and demographics or something. Depending on how the comments come in we may group some of those things together. The different things that relate to view and download and summaries for patients and things like that we may group in clusters because many of the comments are certainly coming in that way. Obviously, where it makes sense it will make things more efficient, but you will have a thorough assessment of all the comments that came in or a synthesis of them so that you should have a week before your April 5th meeting. Then you can have plenty of time to process that in advance of our full day meeting.

Paul asked me to give some sense of where comments have come. I sort of want to state that I have not reviewed all of the comments so this is sort of just some high level things that you can kind of surmise. There are a lot of comments that have come in on the timing and aggressiveness of moving forward. There have been many comments on both sides of that issue, so certainly there are a lot of comments from providers and HIT vendors that have suggested that the policy committee's recommendations are too aggressive. On the other hand there are many comments from consumers, purchasers, these management organizations, health IT advocates, health plans, some of the other technology vendors that are not necessarily the sort of standard HIT vendors that have also come in suggesting that there needs to be a lot of aggressiveness in how the meaningful use framework moves forward. So, those are coming on on both sides and when we do come we will have a paper. In addition to all those objectives, we will have a paper summarizing all of those comments around the timing and aggressiveness as well.

There have been some comments that are probably as much for us internally as for you, which relate to some better alignment between the meaningful use regulation and standards and certification regulation. So we have begun some discussions internally about how to try to make sure that we help to achieve that and so that's something that we're working on. There certainly have been a lot of comments related to providing better definition of some of the new objectives and the specific elements of those objectives. In some ways, that kind of goes without saying, I think that in the request for comment there wasn't necessarily an intention to be fully specified in terms of how things would be measured. Obviously, that's part of why the comment was put out there to try to get input and, certainly many comments have come in along those lines.

Related to the issue of the objectives and the number of objectives, there certainly have been some comments coming in related to merging objectives or perhaps presuming some objectives. That is, if an objective is proposed that in a sense presumes the need for some other data element already to be collected, there has been some comment suggesting that that would mean that you could, in a sense, retire the more foundational objective. So that's something that I think is worth, something that the work group did talk about before, but something that's worth considering as well.

There were some things that are coming that were not in the request for comment. So we will provide information about those things as well. Paul, for example, mentioned imaging. Other people brought up things like shared decision-making, things of that nature. So, people are bringing up other things that they would like the Policy Committee to consider and we will certainly let you know about those things.

I think that's probably about as much as I have in terms of the high level overview. So, I'm happy to entertain questions. Obviously, I can't really get into a lot of detail into the specifics because, as I said, I have not had the chance to read all 422 submissions.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thanks, Josh. Any questions or comments?

Judy Murphy – Aurora Health Care – Vice President of Applications
So, there appears to be a ground swell movement and I've seen many different posts related to this. People sending it back and forth, especially the Healthcare Advisory Board, recommending that people not look at doing qualification for stage one meaningful use in 2011 because the timing for stage two is going to be such that the vendors will not be able to have their code ready for October 1, 2012. Therefore people will get locked out if they start their journey in 2011. Did you see or hear a lot of comments around that, Josh?

Josh Seidman – ONC
Well, as I said, there certainly were a lot of comments around the timing of stage two, in general. I certainly saw it mentioned. I can't say that there were a lot of comments. There certainly were not a lot of comments on that specific recommendation, but again, as I said, I have not read all of them so I can't say.

Judy Murphy – Aurora Health Care – Vice President of Applications
Have we specifically set a timeline for when we think meaningful use stage two is going to be out from CMS in the NPRM? Is that the end of this year?

Josh Seidman – ONC
Yes, the current timeline is for CMS to publish the NPRM by the end of 2011. The Health IT Policy Committee will be making its recommendations around June of this year to HHS.

Christine Bechtel – National Partnership for Women & Families – VP
Josh, are you saying publish the NPRM or the final rule by the end of the year?

Josh Seidman – ONC
The NPRM.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The final rule, the sort of little sub-investment rule would be add two years to the last time, so the final rule would come out in mid-2012.

Judy Murphy – Aurora Health Care – Vice President of Applications
I think that's the concern. If that comes out in mid-2012, then that would be when the vendors find out about it and it, hypothetically then for somebody who is qualifying on stage one in 2011 and 2012, they have to actually for the full year be on stage two, starting October 1, 2012. That would give them no time to get new code from the vendor—well, the vendor would have to develop it. They would have to get it certified; the client would have to get it installed and be able to demonstrate all in three months.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, Josh, I don't know whether you can answer this question, but one of the possibilities that has been out there—and I don't know whether it's something ONC would want the Policy Committee to weigh in on—is the possibility of having a reporting year scheduled to be a full year after the first 90 days of having it be a 90-day begin when you advance the stage. Is that something that ONC feels, ONC/CMS feels is open and would invite Policy Committee input on?

Josh Seidman – ONC
Yeah, we would certainly invite your input on that question and, again, I think that there are potentially a range of alternatives that you may want to discuss. Obviously, part of how the issue is dealt with in stage one is having a first payment year that was only 90 days; that has its pros and cons as well, but it does mean that, in a sense gives providers an extra nine months in that first payment year from what they would have otherwise. So, obviously, there's the 90 days, obviously there are things in between and there a variety of other options.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This might be one of the high level things we can discuss before April 5th, because we'll probably be in the details of the various category objectives and criteria. So as a high level thing, we may want to talk about this on the March 22nd call because that's something we know about already, if it clearly between a number of constraints it's what in the law, the 2015 is sort of baked in. The stages have its logic behind it; you want to move people in either escalator or stepwise fashion. Yes, there's caught between in terms of the juxtaposition of the final rule and when people can start getting payments really poses a challenge.

So, what flexibilities can we—and, Josh, maybe you might offer some of the latitudes, the range of things we can consider. We can start deliberating that in the next call as far as what makes sense and try to be as true to the original objectives and the logical progression as possible. Yet, it's really it's feasible to have people that have a rule and three months later have something implemented, so that becomes a problem.

Josh Seidman – ONC
Sure, I'd be happy to put together a list of what the various options are.

Judy Murphy – Aurora Health Care – Vice President of Applications
That's a great idea for the next call, Paul.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Paul, on that topic still, we may need CMS input on what's the flexibility on the timing of the stages now that it was published. In other words, although the ideal thing might be stage one for the first nine months and then stage two for the last three months. That may be infeasible for CMS to implement. Rather than pulling it back nine months, can we push it forward three months, which is a smaller change and thus, in

effect, move the stage, make it a full year stage, but in the following year and whether there's flexibility on that. In other words, stage two, for the 2011 adoptives if stage two starts a year later than is stated in the final rule. That's the question.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Rob, do you want to respond to that?

Robert Anthony – CMS – Health Insurance Specialist
Yeah, I think we would like to get the feedback from it. I think we're sort of in the middle of looking at our systems right now and seeing exactly what is feasible as well. So it certainly doesn't hurt to get that feedback from folks and then we can follow up on our end to see, there are a lot of systems to check and see what exactly can be done on our end as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Also, just the option of moving—and this might be overlapping with what George suggested—is there flexibility of moving stage two itself when it starts, with respect to stage one. We have them in two year cycles, is it possible to push stage two towards stage three? That might be something you can give us an opinion whether that's a flexibility that's allowable.

Robert Anthony – CMS – Health Insurance Specialist
I think we're also trying to see what type of an option we have in that regard. Part of this is for us a collection of feedback, which we can then take and elevate internally to the next level so we have a chance to take a look. Part of this is really going to be we're going to consult with a general counsel, we're going to look at the feedback we get from the industry as a whole, and we're going to use that to inform how we break those things down. So, again, I would say that's useful feedback to get.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, if you could, just like Josh can provide us with some options, so for example, if this is solely an internal CMS ruling that you already have some ideas and you're checking with general counsel, for example, that may or may not need our input. If there are considerations, you're saying what's the pros and cons of shifting stage two towards stage three? We can't do anything about the 2015 and you would like our opinion, please let us know and we'll try to weigh in on that.

Robert Anthony – CMS – Health Insurance Specialist
I would think the latter, because I think part of what we want to consider as we're going forward is not just internal considerations, but we also want to get some industry feedback as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, well, we'll put that on our list. So, this whole area of how to deal with timing, I'd say that's probably the top, at the top or in the top couple of feedback we get from industry. I don't think there's a criticism about the purpose, the intent of the legislation the way it's executed. I think timing has just become a real practical concern and so I think that's one, we can just take up that big issue on March 22nd with some input from both CMS and ONC in terms of the flexibility and latitude and options. We'll be happy to try to weigh in on those things.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, if I could just suggest one other thing in terms of the piece that Josh might be putting together and more options. I think we also need to know the size of the incentive all the way through to the size of the cuts as we look at the options for the links of each stage because, obviously, if you push more off later when the incentives are smaller that creates a different behavioral response. So, I just want to make sure that we're really clear about the size of the incentive over time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, I think the size of the incentive is already baked into statutes and that will be one of the ….

Christine Bechtel – National Partnership for Women & Families – VP
Yeah, I know, but I'm saying we need, in the piece that we look at if people are thinking about oh, we are just going to make it longer, but we're going to ask for more, that's one thing. But if you don't understand; we're going to make it longer—stage one or whatever or stage two longer—but we're going to ask for a lot more in stage three, but you're not paying attention to the fact that the incentive size in stage three is really much less, that it's a different behavioral response. I'm just asking for the information to be presented.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct. That will be one of the main things we have to weigh the pros and cons of.

Judy Murphy – Aurora Health Care – Vice President of Applications
Hey, Christine, the other piece of that—and we hear this a lot from our customers—is there's certainly a recognition that the incentives go down, but it is really the penalty phase as you look at stage two and three that have a lot of the customers worried. So I think there is certainly the balance that the incentives will go down, but I think there is that carrot and stick that is still out there that has people continuing to pay attention and move forward.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The vendors will have to have the function, so the idea here is that once we get folks on this escalator, a lot of the things will be carried up and they probably won't want to not implement things that are going to be helpful to their formation. Anyway, we'll have this discussion next time, but these are exactly the things we should be discussing about and we have been and it's helpful to know what our parameters are. The other thing that tweaked my interest was the notion of sort of subsuming objectives. So, I don't know that we've thought about it as much, we've always worried about parsimony and also Christmas lights, so maybe there is a role for us to deliberately think about ten as we move from state to state, can we relax some of the other things because they're subsumed by a more advanced criteria objective. Anyway, that's another consideration.

Are we ready to move on? So, actually precisely on schedule, we're going to look at topics for later in the year and we currently have a tentative plan to have an additional hearing regarding specialists scheduled for May 12th is it—no, the 11th.

Judy Murphy – Aurora Health Care – Vice President of Applications
May 13th.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
May 13th, yes, I'll get it eventually; May 13th as a face-to-face and the reason it's pulled in from later in the year is because this kind of discussion would also be helpful to the Quality Measures Workgroup, so we're trying to provide this information to their Workgroup as well as our Meaningful Use Workgroup.

Josh Seidman – ONC
Paul, I believe there was a discussion about having it be both workgroups holding the hearings I think, or was that not—?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's not a bad idea. David Lansky, do you want to weigh in on that at all?

David Lansky – Pacific Business Group on Health – President & CEO
I think it's a good idea and we did talk about it and I think the question of whether we get the convergence of the agenda is the thing we should talk about.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Well, that would be a very meaty hearing. Okay, so speaking of that, what kinds of issues do people have—topics for that hearing? I'll put one on the table and we can just talk about it, quality measures. I've been back and forth with Josh and Tom Tsang about this whole notion of how—it's just the nature of the field. Most of the quality measures that are currently NQF endorsed supply to primary care or at least the specialty areas that are targeting high prevalence health conditions and that doesn't cover the whole field of specialists. So some of the questions that arise is, well, you're supposed to do on the EP side three core or alternative measures and even those don't have universal applicability and then three additional measures.

So, the question is, "And if this doesn't apply to me, then what do I do?" Right now I think the answer—and check me, Rob and Josh—is first in the core area you are allowed to report zero denominators if it really doesn't apply to you. I guess one of the questions is who decides to …? The system automatically calculates it and makes the zero and that's acceptable. In the other three measures probably the same rule applies, it just becomes a little bit of a challenge of what measures you choose of your three and if you do report zero denominators you have to test it. There were no other measures of the 38 that would produce a non-zero value. Have I got that right?

Robert Anthony – CMS – Health Insurance Specialist
Yeah, actually you do substantially have that right. For the core measures if none of those apply to your scope of practice you would report zeroes in the denominators of all that. What the system will do is it will kick you then automatically to all three of the alternate core and you're going to put zeroes in the denominators of all those if they don't have any applicability to your scope of practice.

Then if none of the remaining 38 have applicability you would choose three out of that list to report on. You'll report zeroes in the numerators and denominators there. During attestation—well, actually it's going to come up with a pop-up screen that says that you reported zeroes in all of those areas, so you're saying that none of them have any applicability to your scope of practice.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, that's a little clearer. So, the system, just because they're certified to do this, will automatically pop these core zeroes.

Robert Anthony – CMS – Health Insurance Specialist
I'm sorry; I was talking about the attestation module, when you actually go into the attestation module.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so in some sense it is sort of done for you and you just look for anything with a non-zero is going to count in a sense and if you're just left with zeroes, then that's just the way it is in today's world, in today's definition of stage one.

Robert Anthony – CMS – Health Insurance Specialist
It'll depend on what your system is certified for and what kind of clinical quality measures that it calculates, but essentially, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, in some sense there's no penalty for a zero denominator and there's certainly no threshold, a minimum threshold to qualify; you just have to report.

Robert Anthony – CMS – Health Insurance Specialist
Correct. There's not a threshold for clinical quality measures and it is certainly acceptable if all of those clinical quality measures are outside of your scope of practice, just not to report, well, you would have to report zeroes, but not to have information available for them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, one more question on this. We'll try to leave the quality measures, but that has been a major questions specialists have been asking is if—clearly, it's within your scope of practice, let's say, for a dermatologist to record a blood pressure, but they traditionally do not. Let's say, there's no implication that even though it's within your scope of practice, you have a zero denominator.

Robert Anthony – CMS – Health Insurance Specialist
So, are we talking now about the meaningful use objectives or the clinical quality measures? Because I know that the question has come up—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a good point.

Robert Anthony – CMS – Health Insurance Specialist
Because I know that the question has come up for the meaningful use objective about vital signs.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so, I'm talking about meaningful—oh, yes, so that's the 50% rule. So, there is a threshold in terms of having something, 50% in the numerator.

Robert Anthony – CMS – Health Insurance Specialist
Correct. For the vital signs, there is a threshold. I mean that's a core meaningful use objective for eligible professionals.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, that question has come up, so for a dermatologist, let's say, that would require them to have weight and blood pressures and smoking, for that matter, recorded for half of their patients.

Robert Anthony – CMS – Health Insurance Specialist
Now, both of those, well, I'm sorry, the vital signs does have an exclusion for providers who feel that all three of those are outside of the scope of their regular practice, so they actually can claim that exclusion if height, weight, blood pressure, recording those vital signs really don't have clinical applicability for them.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so clinical applicability is a little bit different, well, it is different from scope of practice, but that's acceptable.

Robert Anthony – CMS – Health Insurance Specialist
Well, I think the actual measures have no relevance to their scope of practice.

Neil Calman – Institute for Family Health – President & Cofounder
Are we defining what specialties that's relevant for or not or are we just allowing the specialists to say it's not relevant? I mean, I think there could be a difference of opinion as to the relevance of some of these things in different specialty areas.

Robert Anthony – CMS – Health Insurance Specialist
We have not provided a definition of which specialties it is relevant for and which it is not. Partially because this is a clinical judgment decision, depending on the way that your practice is set up. It's very conceivable that one specialty, a specialist in a particular specialty might record these things and yet another specialist because of the work flow and their practice make up might not. So, we haven't dictated on a specialty-by-specialty basis. It is left up to the individual judgment of the provider whether that is relevant to their scope of practice.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

And, again, the scope of practice, that phrase has one meaning, I think, defined by the state boards, let's say, for different provider groups; that sounds like that's not what was meant in the way it was used in the statute… rule.

Robert Anthony – CMS – Health Insurance Specialist
No, we don't explicitly link that within the regulation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, it sounds like it's a little bit more clinical applicability and you're giving it a lot of individual determination.

Robert Anthony – CMS – Health Insurance Specialist
Correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Well, that certainly helps.

Neil Calman – Institute for Family Health – President & Cofounder
Paul, I'm just not sure that we—I mean, I don't know if it's within our purview to discuss that, but I'm not sure that that's where we would want to end up at the end of this. Because I mean it sort of leaves a lot of discretion in areas that I think people who are advocates would be concerned about. For example, the we diagnose hypertension is often by people getting their blood pressures measured by dentists and by other folks, who if given a choice might … out of their scope of practice, but in terms of the meaningful use of HIT we might very well want to call that stuff out. So, maybe that's put on a future agenda.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that's exactly right and that may still actually come in in our April 5th discussion. So, what's nice is that there seems to be—I mean, I can understand the way it's presented now seems pretty clear to me and that's what you need to execute something today because stage one is out there, but taking that as input we might want to recommend different kinds of specificity in the stage two definitions. I think that's where you're headed, right, Neil?

Neil Calman – Institute for Family Health – President & Cofounder
Yeah, thanks a lot. That's exactly where I'm headed.

Josh Seidman – ONC
I think that part of the idea behind the hearing is to sort of put all these issues out there and for both the Quality Measures Workgroup and the Meaningful Use Workgroup to have this discussion because I think Neil's right. We certainly hear from other groups that there's some concern about things that really should be measured by everybody or at least by most specialists that might not be getting measured and so I think both sides of those issues should be discussed.

Neil Calman – Institute for Family Health – President & Cofounder
Yeah, and I think this is going to come up in more than just the quality measurement stuff, right? It's going to come up in who's responsible for getting people copies of their records and I think we're going to be called upon to make some decisions about some of these roles of different specialists, but I agree. I think a hearing will be very informative and probably should think about putting some of these questions out in front of the hearing for some of the things that we want people to respond to.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's exactly where I was going with this, so an example of question to pose to the panelists would be the whole notion of clinical applicability and hear the range of their interpretation of that. Another kind of interpretation is, well, does it just have to be in the record no matter whether I put it in the record or a licensed or unlicensed professional put it in the record or another provider put it in the record. That's

another area of flexibility, which may or may not be relevant. Other kinds of questions we would like to pose and we'll record all these and then divvy them up, you know, categorize them in maybe panels, but these are options we're trying to elicit for questions to pose.

David Lansky – Pacific Business Group on Health – President & CEO
Paul, can I try another tack on this? I don't know where it leads, but I'll just think out loud. From coming out of both Quality Measures and the Information Exchange side, when I think about the distinctive circumstances for specialists in our program there are some functions that are necessary to support the kinds of measures that are typically high value for specialists. Those functions, given the roles specialists are often playing as consultants and relatively short-term episodic involvement in the long-term course of care or around a specialized condition, that at least three of the functions strike me.

One is data exchange and we've talked some about closing the referral loop and all the elements associated with that. There's sort of longitudinal data capture and longitudinal patient monitoring and that often requires, obviously, data exchange, but also multiple data sources and multiple data measures, point in time measurements repeated. Then there's the patient source data around patient reports and outcomes or symptom changes and those three, in particular, tax the in the office EHR model.

Then secondly, as we talked a year ago, or a year and a half ago, typically registries are one of the platforms by which specialists are able to aggregate data over time and do the more elaborate computations that are needed for assessing both performance and devices and whatnot in specialty. So, we can think of a registry as just another element of the data exchange structure for purposes of this without trying to, I think we decided when we looked at registries a year or so ago we couldn't really look too far down that path given the lack of consistent development of registries across the various specialties.

So, I'm wondering if we could begin to think about what are the meaningful use requirements that really support specialty care and I just have three in mind, and then what are the implications for cross-cutting quality measurement or common or persistent quality measures that are probably associated with some of those typical specialist functional requirements. Maybe we could come up with something that was a little more elegant and cross-cutting. I guess what I'm afraid of is that for 20-plus specialties we're going to have to come up with a menu of measures and sort of re-invent PQRI. That maybe it's necessary, but it's kind of daunting and if we could find a way to bridge between the functional requirements and the quality measurement competencies, that would be a piece of what we'd want to do.

The other thought I had is whether there's a way to go after clinical decision support and the way clinical decision support programs are populated with guideline-based data or appropriateness criteria or other things that would be another angle for us to get at. So, part of what I'm thinking is if we could come up with this list of three, four, five sort of competencies or functions we could ask the people at a hearing to comment on how they are operationalized for their specialty and maybe come up with something that was cross-cutting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think those are excellent suggestions, David. I think in the cross-cutting, as an example, we can go more towards this whole assumption instead of having all of these pockets and silos of quality measures to the extent that we can have cross-cutting. Then there is some way each specialty can decide which ones are relevant to them and they have a role in this whole team approach of multi-specialty team dealing with these different conditions then that would start moving people both towards teams and a more parsimonious set of quality measures. That's nice.

Another function to add to your list, David, is longitudinal care plans. We'll see what we get from the NPRM or the RFC, but that's something we didn't have a good definition of and it would be wonderful to get specialists opinion of that, how they participate in a more team-based and longitudinal oriented care plan.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Paul, another functional aspect maybe David covered this one, again, is we spent a lot of time in looking at, for instance, exchange of referral documents and that type of thing, so if that could be considered as we look at the HIE or the data exchange element.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We talked before also about problemless reconciliation analogous to MEDREC.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, so, again, it's just what are those key, and sometimes you hear it's five elements they need so it would be really having that vantage from the specialists, I think, would be really valuable.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I agree with David a lot. I think that we really need to—I mean the things that will succeed are those that both the public and the specialty agree are important insofar as we're imposing things that we think might be good for public health, but completely changes their workflow. For example, if they end up having to do a PCP workup as part of their follow-up as a subspecialty follow-up is that we're going to get a lot of resistance. But if as we take these things, whether it's hard to argue how important this is for the patient, I think we'll have greater success.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Along this line, David, what do you think about using care coordination as the overarching theme? I know you started down the road of health information exchange, but maybe the clinical concept—and I'm drawing on what George said, which is something that clearly makes sense to the patient and the specialist and the primary care physician. So care coordination really requires HIT support for HIE and these kinds of longitudinal kinds and cross-cutting kinds of functions. Does that make sense to you?

David Lansky – Pacific Business Group on Health – President & CEO
It definitely makes sense as one big domain. I'm not sure it's complete, but there are other domains that we expect specialists to perform well at and use information for, but I think maybe we can come up with just two or three big buckets to organize the discussion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. Would HIE fall into care coordination, though, giving it a much more clinical and patient-centered kind of an orientation.

David Lansky – Pacific Business Group on Health – President & CEO
Yeah, I think that's right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay and then we can find other buckets.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, I was thinking about care planning as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, yes, we mentioned a longitudinal care plan. Oh, you mean you think as a different bucket or under care coordination?

Christine Bechtel – National Partnership for Women & Families – VP
Yeah, I do because I think that sometimes specialists become the de facto primary care provider. I was talking to some folks yesterday, particularly in oncology where the specialist really becomes the primary care provider for a period of years to treat an acute condition or sometimes a chronic condition, but there

often is kind of a transition back to primary care. So I'm thinking that for those providers where they become the de facto kind of primary care that care planning might capture them in addition to care coordination.

Neil Calman – Institute for Family Health – President & Cofounder
Actually, Christine's comment points out that maybe who puts it in, we shouldn't be regulating that. Because if a specialist is serving as a primary care provider we still want certain PCP things to go in the record, whereas if PCP is also seeing them then it's okay if the PCP takes care of it, so having that flexibility may be a positive.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's interesting; it reinforces the whole team-based concept. So, the proposed rule would say, hey, this kind of information both the longitudinal care plan, whose on the team and the different data elements that are important to this individual's care needs to be in the record and, you, team figured it out. Now, that leaves a lot open, but I don't know how you manage that, but that would fit the goal.

Christine Bechtel – National Partnership for Women & Families – VP
I'm not sure if that's the right approach, Paul, because I worry for the same reason I think you're probably a little bit taking a pause anyway. So, I wonder, though, if this is something that we could figure out in the hearing and ask a specific question on.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yeah. Good idea. Other big buckets?

M
Well, consumers, it's a little bit different than care coordination, so what is it with specialists and consumers we specifically want to cover?

Christine Bechtel – National Partnership for Women & Families – VP
I don't think this is the right level, but one of the things that I've been really thinking about going back to the quality measurement piece is the fact that there often—when we think about the work that the tiger team on patient and family engagement did in quality measurement they, I think, are very applicable to a broad set of providers because they are not condition-specific. They're really patient-specific. So, I don't know if they're sort of a patient-reported data/quality measures, things like functional status or experience that we can ask the providers a question about in terms of being broadly applicable to them as far as the quality measurement strategy. Then the other thing that I'm really worrying about is the patient accessed information if you've got five specialists on your care team and you're really only through the portal, how we make sure that we've got that download capability so that people can, in fact, aggregate their own data. But I think that's almost a technical issue more than a provider issue.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, I'm playing with some different thoughts. There's this whole consumer discussion that stimulates the thought about having consumers represented some time during the day and I'm wondering even if it's still under the rubric of care coordination. So, from the consumer's perspective they have a certain need when they visit more than one physician. From their perspective, how can both their information, but also their care, be coordinated across the people that they see? From the specialist's position and the PCP, so all of these three different big buckets—specialist, primary care and consumer—can have a perspective on care coordination and can provide their needs for information support of that and from that we can extract functional requirements of an EHR/PHR/HIE. Does that organization make any sense?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Paul, patients certainly can do that, but the people that really know care coordination are really care managers. I mean, these care managers have to coordinate care. They will have incredible feedback, I think, in terms of what would make care management of those patients, especially a lot of them take care

of high priority condition patients to make it easier so I would think we would want that group to be included in the testimony, too.

Judy Murphy – Aurora Health Care – Vice President of Applications
A lot of those care managers are nurses and I think, again, care coordination is probably in the bailiwick of nursing as well.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
But I think there's also a lens that we ought to look for here, which is what is it that patients need in care coordination and I would add care planning that technology can support, how are they willing and able to access the system and be an agent of change and facilitate care coordination themselves. Then what is it that they need providers to do at the same time in terms of giving them kind of tools and having a good partnership and relationship. If we have that list, I'm fine with having, I think it's a good idea to have the extra piece of care managers as long as we understand that we are asking them to think about it from a patient perspective as well.

Judy Murphy – Aurora Health Care – Vice President of Applications
I think that's a really good point. I think the idea is that the nurses and/or the care managers are probably the ones that are going to facilitate the patient taking some of this one. It's not going to be magic overnight, the patients all say, oh, yeah, wow, I should take accountability for my own care. So, part of that transition, I think is the patient advocacy part of that in helping them see that this is something they need and actually need to be involved in.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Well, so our research probably says a little bit of the opposite, Judy, which is that when we talk to patients who have multiple chronic conditions and their caregivers—so these are the hardcore care coordination folks—the challenge was not that they didn't understand their role or weren't willing to play it. The challenge was they had such wildly low expectations of the providers that they took on the burden of care coordination themselves and expected almost nothing from their healthcare providers.

Judy Murphy – Aurora Health Care – Vice President of Applications
That's interesting because that's certainly not our experience here. Patients that we see generally here in Milwaukee, Wisconsin really completely delegate this activity to the care providers and still don't see that they could really make a difference if they participated more fully. So, it's probably the continuum is probably the answer here, right?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Well, I think that's part of it. I think part of it is also not being accustomed to having the tools and resources to play that role because it's really hard when you have to request electronic copies of records. We've got example after example of people building their own—patients and caregivers building their own—spreadsheets, sending them to doctors who don't look at them, requesting doctors to send their lab results to the other doctors on their care team and they don't do it. I mean, it's really been a challenge in not having the system. So, it's first sort of expecting it to happen, they don't; and then when they want it to happen and they try to get it to happen and it doesn't. So I think there's sort of a tool and systems approach to this as well.

Judy Murphy – Aurora Health Care – Vice President of Applications
Really good point, interesting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me try to tease out this bifurcation, this fork in the road. So, one approach, which might have been, let me call it a little bit more traditional is to invite a panel of specialists and say what do you need out of an HIT system and you'd say the same thing to primary care providers, you'd say the same thing to consumers, you might say the same thing to care managers. Another approach is to say, look, what we

really need in order to take this next step in dealing with health and not just with sick care is coordination of your health related issues all together and have everybody look at that as the main focus from different lenses, different perspectives. So, instead of what's in it for me and silo it off into various groups, bring the various groups into it and look with your perspective, but the goal is coordination of care and longitudinal health plans. Let me bifurcate, and maybe I shouldn't be taking those two polar extremes, but to get the sense of the group, which construct seems more useful in this hearing?

Christine Bechtel – National Partnership for Women & Families – VP
Paul, I'm not sure I'm picking up the difference in how it would manifest other than maybe having the panel not be patient panel, provider panel, but be integrated so we have providers and patients on the same panel.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think it's that and then the framing questions invite people to take a look at it more from—ultimately the patient's point of view, so if we're going to manage together, that's both the professional side and the consumer patient side. If we're going to manage these chronic health conditions, how do we do it supported with good information and take the different perspectives on a single panel and ask the framing questions with that in mind?

Neil Calman – Institute for Family Health – President & Cofounder
I think that's the right perspective because otherwise what you get is people sort of protecting and trying to limit once the requirements are going to be on that. I think by posing it and saying here's our ultimate goal, which is to have coordinated care with a focus on … and everything, from the patients point of view you force people to sort of get outside of their own sort of self-interest and start thinking about what their responsibility is to the patient. I really like that framing.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, I agree.

Deven McGraw – Center for Democracy & Technology – Director
Likewise, it's Deven.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good. Because I think what'll happen is we'll see some interesting interplay and it will get much closer to the cross-cutting kinds of measures and functions that we were looking for and we'll be able to derive the HIT support better by understanding these goal oriented needs.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes, I just would say I like the idea of this panel you're describing where there would be this interaction. I'd suggest as well that there be someone with a particular interest in population or public health be a participant.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, now it's getting big and I wonder if that's another organizing theme. So, one organizing theme is the partnering, team-based management, which of course includes the consumer and the family on chronic health conditions of individuals. Then there's another theme maybe in population management. It may even involve the same players with the addition of public health, but a different framing question. Would that make any sense, Art?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes, I think so. I thought it was interesting that you used the words in their health and not in their healthcare. So, that got me thinking, well, how can HIT help public health support the health of all those participants in the process around a patient?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, that's legitimate, but I'm also giving it a bigger role and having a different panel that shifts the frame.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Could be; I think it could shift. I don't think they need to all be on the same panel, that's right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Other thoughts?

Art Davidson – Public Health Informatics at Denver Public Health – Director
I just want to go back to David Lansky because I like the trend of this discussion that we're having and the focus on the team and the continuum and the planning. But the specialists—this idea that David brought up about their registries and how the registries serve them. How does HIT or the EHR support the development of a registry when the specialty may provide for them benchmarks or may provide for them a place to aggregate enough data for us to find a bad event or some adverse reactions to a device? So I think that's what David was trying to get to and I don't think we need to have the group of specialists come back and demonstrate all their great registries to us. I think it's more about where is the HIE and the EHR enabling that process of a specialty sponsored registry that allows them to reflect on their practice or how their practice is doing compared to others.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, I think your comment stimulates another thought and it fits in this population health focus panel, so instead of, like you say, registries as an end point, registries can be a way certainly to support population health, but let me add a consumer perspective. So, when I have side effects or a provider's perspective, an EHR user, when I find something that seems like a safety issue within EHR, how do I aggregate it, as you said, so that it can be investigated more, you know, we can pick out trends as they emerge? That all would fit in the sort of population health kind of surveillance monitoring and action bucket. Does that make sense? It opens up this whole thing and it includes consumer and users, like provider users.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Indeed. I think that's an excellent point. I was just going back to this concern about how do we get the specialists engaged again? I think that's where David was trying to point out a gap, but maybe through this approach you're saying. I think they do routine surveillance whereas when an adverse event is a happening, it may be that you find it through routine surveillance or a couple of people just get together and say, hey, something bad is happening here.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, I think that also calls out the need for coordination because a lot of times they're not the ones who actually are caring for the patient when those adverse events occur. So, unless there's some sort of … that database whatever they think is being maintained as sort of a complete database and registry is really not complete unless it contains information that other people are collecting in follow-ups or whatever that specialty people are doing.

David Lansky – Pacific Business Group on Health – President & CEO
I really like Art's framing of it. I think we could imagine some bullet points or questions underneath, for example, the population health management heading that would invite our people at the hearing to respond for their specialty about how there is a benefit in this kind of either data aggregation or feedback system in trying to capture some of the learning system ideas that are implicit there in terms of benchmarking aggregation, enabling clinical decision support rules to be learned and fed back into the system, outcomes reporting for various purposes. There's a whole set of data aggregation population level functions that we could bullet out and then try and get different specialties to comment on how those things are in the best cases operationalized in their area.

I was also thinking that maybe as we're looking for witnesses—sort of best in class. People who have been doing this for five years or whatever in their field and have already gone fairly far down the road of discovering what they need to improve practice and to engage with their patients and all the other things we're talking about. If we could get them to sort of tell us what are the expressions of these things we're talking about right now that have really worked in oncology or dermatology or whatever, that would be really informative and from that we might be able to infer these cross-cutting things.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So when you say the chronic condition management that's partnering a specialist with a PCP. As we start to talk about population management, we're trying to partner specialists with identical specialists in other areas so they can create this learning health system. So, it's leaning outside the scope of meaningful use, but the question for the specialist given that we're trying to create a community of specialists in each are, what can meaningful use or the EHR do to potentiate that? One would be the availability of data so we can discover side effects, unknown side effects of treatments, but there may be other things that they think of that the records supply. For example, it might be something like certification or something to do with what they have to do as part of their—because as each resident goes through, they have to log how many cystectomies they do or whatever. So there may be other things we're not thinking of that we could be helping specialists with and asking them that question may not be a bad idea.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's interesting stuff. As you spoke of sort of trying to frame, so far we have two big buckets. One is on care coordination and the focus truly is on individual health and there's different perspectives on how do we marshal all the resources and make sure we're supported by the data to effectively maintain the health or improve the health of the individual? The second bucket we labeled as population health really seems to focus on the data. You can use the data for multiple purposes. For individual field, individual specialty it can be a registry and the sort of the things that its currently served; in the public health you're looking across an entire population and what George just said is then you create a learning health system, let's say, even amongst specialists. How can you leverage that data to cause a learning health system and improve the knowledge and maintenance certification?

But it's the focus seems to be how do we leverage data in aggregate to improve overall health and knowledge. Do you see what I'm saying? Two sort of organizing themes; one is the health of individuals and the other is population health that I can recast that just sort of looking at aggregate data and what people have been talking about are multiple perspectives on how do I use that data and mine that data to improve care and knowledge.

M
Paul, we're going to run out of time if we're not careful. I agree with what you said, obviously, so now do we need to start thinking about the actual panels and participants today or is that what we can do on the 22nd or in e-mail? Remember, there's another topic we were maybe putting into the specialist panel, which was imaging, which we should just mention for a second and then we've got to do the experience panel and any other panels that we can think of.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. So, how do people feel about these two big buckets, care coordination and population health focus on an individual and focus on population data?

Neil Calman – Institute for Family Health – President & Cofounder
I guess my concern is I just don't want—I guess I think, when you said, Paul, before about the coordination sort of being a major theme, I just think we need to make sure that that comes through in the specialty piece. That this doesn't just become sort of specialist reporting, you know, this community of specialists to me is less important than a community of providers. Because a community of specialists tends to think the way the specialists always think, which is that the only thing that's important is the stuff

within their purview. I think the opportunity we have to really call out a different model of care is really important and we should make sure we do that in both components of what we're asking people to do.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, fair point.

Eva Powell – National Partnership for Women & Families – Director IT
I would echo that and just say that I think the challenge here is to figure out that sweet spot where challenging. Then going against the current work flow is exactly what we're after because the current work flow does not support the kind of care that the American public needs and so that may—I don't know that that's an explicit question to ask. But somehow in the testimony we need to get at where are those places where the work flow, when supported through better information and the electronic capabilities that will enable that can change and should change, even though that will be a difficult process and where are those work flows that currently may be working or may work better if some other things change. I think that's kind of an unspoken challenge that we all have in front of us. The providers always talk about their work flows and how this just doesn't work with their work flow, but in some cases their work flows need to change and I think we need to be upfront about that, but figure out with their help, where those places are.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, other comments about these two buckets?

Marty Fattig – Nemaha County Hospital – CEO
Just listening to the conversation, I think it's real important to remember that most chances for error and harm occur at transitions of care. If we can promote a system where the data flows freely between those transitions of care, I think we've been successful and I think what we've talked about here with the care coordination and population health will do that. I do agree that we have to keep that coordination of care piece flowing through into the specialists as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Well, there seems to be really strong agreement with the care coordination bucket and having the different perspectives, but oriented in that direction. Does the same apply to this population, health population data kind of bucket? I think in both we're trying to somewhat break down the barriers, the silos between different kinds of providers and focus it more on the end goal, which is whether it's the individual health or population health. Is that a fair construct?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yeah, just sizing it, I would think care coordination is a huge topic. Whether it's two or three panels, I'm not sure. Then the population health that we're talking about, I think it's good to have the specialists speak their mind about what they think they'd find useful and that would be one of the panels. So, I think it's just a matter of size and that goes along with Neil's comment about not losing care coordination.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I kind of like the way that Eva pointed out that we can pose the question, as she called it in that sweet spot. Maybe we don't have that worded right yet, but we can challenge the specialists to not just parade what they think are their best practices, but identify what are the gaps to helping support population health. So, I think there was some sort of balance or tension between those two questions or ways that she described. I like the idea and I'm certainly in favor of the way that George has posed maybe a little more emphasis on care coordination. He's certainly spent more time talking about that, but there is an opportunity to engage the specialists and others in this population health perspective.

Michael Barr – American College of Physicians – Vice President, PA&I
Paul, Two quick points; great conversation, I support everything, but two phrases haven't been used so far that I'll throw out here as potentially organizing principles. The… organizations, which would have to

do a lot of the things we've been talking about and the whole patient centered medical home neighborhood concept, which speaks to the primary care specialty relationship and the transitions of care and the sharing of information, the exchange of information and agreeing to share care or when the specialist becomes the principle care provider. So a lot of those concepts have been fleshed out in policy papers and in discussions might inform some of the panel discussion, too.

David Lansky – Pacific Business Group on Health – President & CEO
Paul, I have one other thought; I'm not yet totally sure that all the things that, at least, I'm thinking about are going to fit into these two buckets. The concern we have about specialty care is clinical decision-making and the use of information, whether from the patient or from outside the care setting to inform those clinical decisions and then be accountable for them. So, whether that's treatment selection, device selection, all kinds of referrals and recommendations for post-acute treatment, so that might be under the care coordination, but I'm really thinking about how does information get into the hands of the clinician and the family and the patient at the point of care and I wouldn't want to lose that. So either that becomes bullet points under—care coordination seems like it's going to drift towards information exchange among the care team, among professionals as opposed to bringing guidelines, best practices, shared decision-making, other modalities into the critical high cost, high variation, high risk treatment decision-making, which IT should be supportive, should be a very powerful tool to support good decision-making.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So, I think what you're saying is, I think I see where you're headed, which is how do we word clinical support guideline evidence-based medicine into the hearing. So, on the one hand it seems like it's captured under meaningful use and what you're saying is we haven't paid enough attention to the areas that involve specialists. Okay.

David Lansky – Pacific Business Group on Health – President & CEO
I'm also thinking the quality measures typically that correspond to these specialties tend to go after some of those issues in clinical decision-making and turn them into metrics of performance, so in part what I'm trying to do in this conversation today is think ahead a little bit to the quality measurement implications in these domains.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right, so sort of like the use, it's almost database practice; it's data creating evidence to inform practice. Do you think that may be a third bucket?

David Lansky – Pacific Business Group on Health – President & CEO
Well, as I said earlier, maybe we can get at it if we make sure there are sub-points underneath these two, which get at those. But it might be a third bucket, I'll just put that out for discussion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, George already suggested we might have more than one panel for "care coordination" or focus on individual health and maybe there's a subpart of that that has a lot of questions that are directed in the area you're suggesting.

Neil Calman – Institute for Family Health – President & Cofounder
Just to throw out a totally different thought. Would it be possible—instead of breaking up the panels along those lines to break them up along specialty lines and have each of the specialties—the leaders that we would bring in in the specialty areas talk about the domains of meaningful use and do some sort of forward thinking about the domains of meaningful use and how they affect their specialty, which would get into measurement of quality? It would get into some of the safety concerns, it would get into some of the decision support stuff, care coordination, you know; it sounds to me like we're breaking it up, but what we really want are all the specialties to sort of think about those areas, all the domains of meaningful use.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, that was sort of the other fork of the road that I was trying to propose, we sort of take one or the other approach just because we can't do both, I don't think, together. On the one hand was the look at from only the perspective of specialists and serving that individual specialty versus the cross-cutting nature, so care coordination once the specialist role, the PCP's role, the consumer role in getting coordinated care for an individual and I thought we were headed more in this latter approach. Another logistic reason, well, what do you do, you invite 50 specialists and go down that road for each one of them or what?

Neil Calman – Institute for Family Health – President & Cofounder
Well, the reason that I'm suggesting it is as we're talking about it, it just sounds like all these things are so inter-related. The measurement is related to where you get the information from and everybody is talking about them like they're all—it's feeling more and more artificial, the division between care coordination, population health and whatever. What we're really saying is these are the domains of meaningful use and we need to do some forward thinking looking towards the future in how each specialty area can contribute to these and what we can do to sort of call out the things that would support those specialists. Anyway, I won't push the point. I just think it's getting sort of murky anyway and I'm just afraid that breaking up the specialty panels into kind of like some questions going to one and some to the other won't really lead us where we need to be.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I don't think either we're going to be clean from that point of view. Okay, George is reminding us time is short. Are the people on this call, it was originally scheduled for three hours and it's my fault for thinking we could do it in an hour and a half. Do people have more time than the hour and a half?

Neil Calman – Institute for Family Health – President & Cofounder
I do.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I can do some more time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, it looks like we can carry on a little bit further, but we'll try to make progress. But for now, could we try submitting questions; let me just, it seemed like the sense of the group was certainly the first category, care coordination, was pretty strong for the group. Could we submit individual questions and, David, this is also a way for you to get the clinical petition support guideline based care into whichever bucket you feel comfortable, and we start finding a way to categorize these within these buckets? We could work on that through e-mail and also submit names or organizations that you think would fit these two areas and then we can prepare a summary of that to bring into our March 22nd call. Does that sound fair?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
That's good, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, while we're here, George raised imaging. We talked about that before and we've heard from them. Would we consider them as a specialty area or a group of specialists dealing with imaging and consider them as one component of both care coordination and population health? Or is there some way you'd want to deal with them completely separately?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I was thinking a half panel for imaging rather than imaging spread within population health and care coordination. It, obviously, has a lot to do with care coordination, but like kind of a half panel worth of presentation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. What else would they talk about other than the care coordination part?

Marty Fattig – Nemaha County Hospital – CEO
Paul, our electronic medical record has the reports from imaging directly included in it. The images themselves, of course, are accessible through the PACS. I guess I'm confused about what the question they have really is.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The question that they posed is, and I think it's common for most EHRs to have reports. The imaging folks have been advocating for having images available.

Marty Fattig – Nemaha County Hospital – CEO
And they are in ours.

M
Well, it's meaningful use of health information technology; the fact that current EHRs don't really integrate with PACS. Now maybe we can't get there too quickly because of the feasibility issues, but ideally it would be nice if doctors could get to the images in a convenient way and that their argument would be that, in fact, it should be an integral part of the environment that the doctor works in whether it's EHR or PACS.

Marty Fattig – Nemaha County Hospital – CEO
Yes, I totally agree with that. I was just stating that our images are available through the EHR.

M
Then the question for them is that a meaningful use criteria and you have to have a PACS system? I don't know; that's the thing to be sorted out. We've kind of shied away from images so far, so what are we going to request?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, it sounds to me—I'm not sure we should force a specific panel, because that just singles out one specialty area. Should we discuss this exact question in our face-to-face and the question being posed is is there a separate meaningful use criteria for images per se? So, it sounds like it's something we have to work out so we can put that on the agenda for April 5th.

M
So then not have anyone testify or yes?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm not hearing a whole lot of push for a separate panel, which singles out a specialty area.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So then maybe have one, just to be supportive of that whole part of the field, another choice would be one of the care coordination panels would have an imaging person. Would that be something we wanted to do?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What does the group think?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I don't know. I'm not sure what we would ask them.

W

It strikes me, didn't we have one of our, did we lose this one, we had one panel organized around the kind of data we were going to be sharing. Isn't imaging a kind of data? Is that panel still intact?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That panel is still intact. I suspect they would be more into the care side. Well, regardless, so George's question is would there be an imaging representative on one of these panels specifically?

W
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So I mean one place the imaging thing comes in more in terms of direct, right, where a provider can potentially send an order through to an outside imaging specialist and perhaps direct the report. I mean, that's the only thing I can think of, unless we're calling out that people have to have PACS systems. What else would we be asking them?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Josh, do you know if the American Radiologic Society submitted, whatever that is, that group.

Josh Seidman – ONC
The American College of Radiology.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right, American College; did they submit a series of comments about meaningful use?

Josh Seidman – ONC
They did.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Maybe we could be informed by what they said they thought was important, because I'm not exactly sure how, I think I'm with Neil, I'm a little unsure where they fit on these panels.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we're struggling on this. Let's postpone this until April 5th and we'll have their comments to take into account when we look at the meaningful use criteria. We can always adjust the panels if there is some compelling reason to add a specific panelist. But it sounds like right now what we need to do is get more information from them and weigh that in the meaningful use criteria discussion.

Okay. An additional topic is experience from the field. What's likely to be available by May 13th, Josh, that we might want to include?

Josh Seidman – ONC
I think that there are, certainly the meaningful use community practice, that's from the regional extension centers would be able to provide a lot of feedback. We will also have begun to collect data from the RECs, that's really the CRN's role by that time, but we'll probably still be in the early stages of that data collection.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Any other field information that would help inform the group?

Josh Seidman – ONC
But I will point out that the priority for the RECs is the priority primary care providers. Some of them have additional support beyond the support that they're receiving from ONC that they might be supporting

specialists to sort of point out that that will be primarily input from the priority primary care providers, which are the small practices and the safety net providers.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that's a good point. So what we might do is if we have available time on that hearing day, May 13th, we can include almost as a separate topic—in other words, we clearly wanted to be informed as much as possible about experience in the field as we move towards our recommendations for meaningful use stage two. We can either get it as part of this particular day or a separate report from them on one of our calls. So, we don't have to push that for this day, but if we do have time that would be certainly useful and it's one of the things we wanted to get input on.

M
So, Paul, when we do this panel or this work, I mean my main concern is sampling bias. I'm a lot less interested in how the top institution in the field given $20 million can achieve the meaningful use criteria as far as like the Beacon Communities or even the RECs where they're here and paid to help people. You know, how do we sample the people who don't have RECs and how do we get feedback? I don't even what feedback we could get at this point, but that's the group that we need to worry about?

Neil Calman – Institute for Family Health – President & Cofounder
One of the things that I mentioned early on was being able to monitor implementation and the extent to which people in the safety net communities, both hospitals and providers I think are keeping up with the rest of the country.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Is there data from vendors we can get?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, do the REC's cover the safety net providers, Josh?

Josh Seidman – ONC
Oh, yes, absolutely.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
They do, but in terms of trying to figure out where they are in respect to implementation and meeting meaningful use in relationship to the rest of the community, that's the issue that I'm raising.

Josh Seidman – ONC
Yes, we can certainly have them address that.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes, because I think they're probably our closest peers and they're really throughout the country.

Josh Seidman – ONC
They serve federal qualified health centers, rural clinics, critical access hospital, other medically needy populations.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
They cover a sample of safety net providers, so we need to also reach out to the safety net providers not in an REC area, in my opinion.

Josh Seidman – ONC
Are you talking about specialists?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I don't think every safety net provider has a local REC; not every safety net provider in the country is associated with an REC are they?

Josh Seidman – ONC
They're not associated with one. They certainly have access to one. There are 62 regional extension centers, which cover the entire country.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Right, that's about as good a sample as I can think of, actually.

Art Davidson – Public Health Informatics at Denver Public Health – Director
And in some states, the safety net institutions I think are actually driving the REC activity. But, I hear what you're saying, George. We need to be sure that we're not leaving someone out, but I think the ONC has done a pretty good job of extending the REC out to that safety net primary provider population.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I just don't want to be patting ourselves on the back. Maybe it's not even the safety net provider; maybe it's the PCPs who aren't safety net providers, but no one noticed them. I want to see what they're thinking and what their plans are for implementing meaningful use and that's the kind of—we're supposed to do the country, so I want to know, or at least know if we're saying that this group of doctors are moving ahead and they're going to be up and running in a year or two, what proportion of the country does that group represent? Is that 10% of doctors or 90% of doctors?

Marty Fattig – Nemaha County Hospital – CEO
Would it be possible to ask associations that represent providers to submit data?

Art Davidson – Public Health Informatics at Denver Public Health – Director
That's an excellent point and NAHC (the National Association of Health Centers) could do that for the federally qualified health centers. I think they have those data.

Marty Fattig – Nemaha County Hospital – CEO
Well, the National Rural Health Association and the American Hospital Association have similar data as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, actually, how long is our call on March 22nd?

Judy Sparrow – Office of the National Coordinator – Executive Director
It's 10:00 to 1:00.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, three hours. Okay, so the big topics, because I'm thinking where would we put this discussion. I think what we can do is we can submit; so we may create a form for you to submit ideas, both on questions for the hearings, these two different buckets, as well as potential testifiers or organizations and then we can report on that and continue this discussion and get down to individuals by our next call. Then the other big topic was on dealing with the timeliness or the timing of meaningful use stage two and stage three, in particular, stage two and different ways of managing flexibility there. Then, well, I think those are big enough topics. How does that sound?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Do you think we'll still be discussing the May 13th panel by then or will that be set?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

I think we will be. So, the homework is to, maybe Josh can help us with a template for us to fill out, on questions we would like to pose to, questions from both the specialist panel and on the experience from the field panel will be discussed on the 22nd as well as timing. Is that fair? Maybe we'll finish on time. Other comments?

David Lansky – Pacific Business Group on Health – President & CEO
I have a question or a comment. I wonder if maybe someone's already done this—we could just have the report or we could do it quickly—is to talk, I'm thinking about George's point about sort of thought leaders versus typical adopters. If someone, we could pick three or four specialties and talk to some thought leaders or professional societies—most of them have an EHR committee or something—and find out prior to one of our next meetings on an informal basis what has been sort of emerging from their field, let's say in oncology, as the highest value functions or features. Or benefits of EHR adoption in places that have been using it for a while so that we would inform our thinking a little bit from some, even if it's a very crude qualitative snapshot of experience from the field, in the specialty areas particularly.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So, we had some of that in our specialty hearing, right? We had, in fact, oncology and the cardio thoracic.

David Lansky – Pacific Business Group on Health – President & CEO
Well, that was about registries, I think, more than EHR in office practice, although my memory is a little fuzzy and maybe it's already been done and we can just go back and grab that, that's fine. I know the oncologists and I think the pediatricians have published kind of field guides to their specialty and what to look for in a product and I just wonder what they think the highest value is for them in their areas.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You might want to review the PACS testimony. Does Beacon cover this at all, Josh?

Josh Seidman – ONC
Sorry, does Beacon cover what?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Sort of how specialists are leveraging EHRs, thinking that they're more advanced.

Josh Seidman – ONC
Well, they certainly are included in their communities, but they're not monitoring it in any great detail, but they're certainly included in the communities.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, are you aware of what David Lansky is asking in terms of either through the EHR committees of these various specialties what kinds of more advanced benefits they're getting out of EHRs?

Josh Seidman – ONC
Yeah, I mean the other thing we can do, getting back to Art's question, we can take some—we will be going through all the comments from all the specialty societies. You can start to get ideas of where they might, you know, if they've talked about how they're collecting data or things like that you could try to, we'll be making notes of that.

David Lansky – Pacific Business Group on Health – President & CEO
Individual clinician specialists that I've talked to, most of their answers are I'm going to do whatever my specialty society tells me to do. That's literally the answer I get from people who have a lone practice in the midst of nowhere.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

So, David, I don't know if we've fully answered your question. You think there's a next step for getting at your question or is it maybe going back to the old hearing, the former hearing?

David Lansky – Pacific Business Group on Health – President & CEO
Well, it needs a little bit of digging. I can do a little bit and we can maybe compare notes. I'll send a list, for example, the oncology one I just pulled up. It's interesting to me where they've gone into greatest depth, where they think the highest value is to them and it tends not to be things we've talked about on this call, so how to capture that. Part of our goal is to obviously provide clinical value to the physicians and their patients, but also to incent them to get involved in the program because we are signaling features and functions that create value for them. That mapping is worthwhile because the thought leaders have already gone down this road and determined where the highest value is by having better information access.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, well, we can certainly take this up on the next call. Okay, any other comments about the hearings?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Paul, I'm just having second thoughts about this imaging and saying, "postponed to April 5th" as opposed to discussion it on March 22nd, say, like having it part of the e-mail discussion. I've been very conservative on imaging because I don't think it's feasible, but I do think it's important and part of our charge. Our charge is meaningful use of HIT, not healthcare reform. It seems as if we're leaving out an objective, the single most important type of data that many specialists use in order to make a diagnosis and follow treatment, that that's a failing. I think it's a calculated failing if we don't think it's feasible for everyone to have a PACS system, but I don't, that we have the attitude that it's not important or it's not kind of part of our planner, just another type of data. I think it's a very difficult type of data and it should be recognized, so I kind of wouldn't mind having it part of the panel discussion on March 22nd rather than saying well we'll just talk about it later on on April 5th.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We can certainly talk about it as part of the panel. So, I think the questions I heard raised on this call is what questions would we ask them. I think the key question is are we prepared to require everybody to have a PACS system.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So, that's the question, what's feasible to do today? What's the next step and it's not just sending a report to the EHR because we already have that, unless that is the only step we can do, so maybe it's suggestions for what we can do that's feasible.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
If you ask that question it needs to be done in the ambulatory settings as well as in the hospital settings, too, because I think that's where there are some gaps in transition, what's feasible.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So you might look at the comments, George, and you can raise those on March 22nd and if the question is they want everybody to have a PACS we could, I mean that seems like a meaningful use kind of a question to me.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Ability to read someone's CD; if they bring a CD of the image of their study, having the software available to read it. That's not as hard as a PACS.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we're getting into pretty detailed stuff.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I'm just saying that's an example of something that might be feasible.

Tom Tsang – ONC – Medical Director
Some of the issues that came up at an imaging meeting Chuck Friedman had is really the integrity of the images that would be seen through the EHR. So right now, there are no standards in the community from the professional society in terms of the validity of those images, who's taking the images—sometimes they could be manipulated. A lot of primary care doctors or specialists who are not necessarily, and I'm talking about non, I'm not talking about x-rays or CTs, but even pictures of dermatologic rashes or whatever. I don't think there are standards in terms of the images going through to the EHR and being viewed by the primary care doc or by any end user, so there are some questions about the validity and standardization.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so I think those questions are better dealt with in a meaningful use discussion, don't you, George? Dig into it a little bit more and see if there are things or questions that are raised at the policy level. Those kinds of things, seems like it's a meaningful use kind of a discussion.

Tom Tsang – ONC – Medical Director
Yes, I think you guys should really deal with the whole issues of images, I mean, if you go beyond x-rays and CAT scans.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So they might be looking at wanting to have; I think it's worth looking into what the actual requests are and seeing where it fits, where it's most appropriate. Okay, are we ready for public comments?

Judy Sparrow – Office of the National Coordinator – Executive Director
I think we are. Operator, can you check and see if anybody wishes to make a comment.

Moderator
We do have public comments.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. Could you please identify your name and organization.

Mari Savickis – American Medical Association – Assistant Director, Federal Affairs
This is Mari Savickis at the American Medical Association. I wanted to thank you for a good discussion on that today and first of all offer up any assistance that we can provide with respect to the specialty societies. We are an umbrella organization and we did submit a robust comment letter, which I imagine is still being reviewed, but there are a number of concerns beyond imaging, which a variety of specialties have come to us on and they're seeking flexibility. This is a long conversation, it's not something we can do in five minutes, but I just want ONC and the Policy Committee to know that we're here and that if there is something that you're looking for us to help you with, if you're looking for certain information, we can help get that to you. ONC has my contact information and I would be happy to coordinate with Dr. Seidman or whoever is the appropriate person. That's my first comment.

My second comment concerns going back to the early conversation on the call regarding the differences of opinion that were submitted with respect to the comments. I was wondering if there was going to be a tabulation or some kind of understanding of the April meeting of the number of comments that came in seeking, say, greater flexibility versus the number of comments that came in suggesting more strict criteria.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you. Another comment?

Richard Eaton – Medical Imaging & Technology Alliance – Industry Manager
Hello, this is Richard Eaton from the Medical Imaging & Technology Alliance. I'd like to make a short comment that as it's consistent with the written comments that we submitted on February 25th we would like to call for an imaging panel be held on April 5th. There are a number of areas of importance that we would like to provide testimony on, including first the criticality of communicating imaging information and how it is important to clinical practice and achieving NHIN and we believe it should be included as a key priority for stage two meaningful use.

Secondly, adoption of the use of the DICOM Standard integrating healthcare enterprise, the IHE profiles and other standards-based tools; we believe these should be key goals for implementing stage two meaningful use and that work should begin now so that all the necessary steps can be taken in a careful coordinated way. So, we would like to call for an imaging panel. We can provide testimony. We believe consistent with what has been discussed today at this meeting that imaging is very important in terms of making a full diagnosis of a patient's condition. I think it is now time that we fully and carefully just look at the entire notion of imaging. Not just from a provider's standpoint as important as that is, but also from the folks who make the PACS systems and the software and the medical imaging devices and how that might be achieved and what the next steps should be. So, we would like to strongly urge that separate time be provided to do that at the April 5th public hearing.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you for your comment. Any other comments?

Moderator
We do have one more comment.

Michael Beers – American College of Radiology
This is Mike Beers with the American College of Radiology. We'd also like to extend our help in any way, shape or form on the imaging discussions. I think there's a lot of confusion right now about what is feasible and I think that's because of the traditional separation between our informatics communities, so I would encourage you to invite us to the table. Thanks.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, Mr. Beers. Okay, Paul, back to you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, thank you. Josh, would it be possible for us to send out a form for us to fill out in terms of the information about the hearing?

Josh Seidman – ONC
Absolutely.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, we'll get that as a way. We'll summarize that for the next discussion when we'll cover the follow-up on the planning for the hearing for the May 13th hearing, dealing with the timing aspects for stage two and other maybe high level feedback we get from the RFC as available at that point in time, going into April the 5th, going into a full discussion in our April 5th meeting on stage two meaningful use.

Judy Sparrow – Office of the National Coordinator – Executive Director
All right. Thank you. Bye bye.

Public Comment Received During the Meeting

1. Can ONC Comment on how many comments were in favor of streamlining / reducing requirements vs those that recommended retaining / increasing the requirements? If they don't have this info now, can this info please be made available at the April meeting?

2. Invested party comments re: Meaningful use would definitely fit well into the focus on individual health & care coordination regarding the individual. Please include AHDI & CDIA, AAMT &AAOA data. AHDI can answer David Lansky's ?'s re: how are health specialists leveraging info of successful EHR's. Please look to AHDI comment on meaningful use submitted or provide an email address to David Lansky & we will be happy to provide immediate and concise answers & input. Any orthopedist would agree that PAX is crucial in making critical diagnoses. Even if they have an official interpretation by a radiologist of an imaging study in hand, they absolutely want to view the image because in most cases the written radiology interpretation does not at all provide sufficient information for the surgeon to decide the best course of action - surgery versus continue to monitor periodically with imagine studies. Often time is absolutely of the essence for example with cancer patients seeing an orthopedic oncologist. PAX is essential. RE: The focus on individual health & the earlier question of how to flag data representing potential safety risk to a patient, there are methods of flagging data within an EMR that represents potential safety issues to a patient, with review process and either verification or amendment of the data that are already in place and being successfully used in EHR systems currently. AHDI can provide comment on successful methods of these processes within isolated EHS systems.

3. Comments on FACA Meaningful Use hearings - comments were made and responded to that although acore set of MU requirements had been established, there were other elements including Behavioral Health elements that had not been included by vendors. Can we clarify that Behavioral Health components are also important and should be included in stage 2 and 3, and vendors are encouraged to incorporate BH components into their EHR systems today. By refocusing this HIT usefulness with this revised focus as patient centric, we may need to revisit the goals for stage 2 and 3 meaningful use. With the patient in the center of meaningful use as a participant, we will also need to be very sensitive about segmented data sharing and segmented privacy/permissions, including behavioral health aspects.

4. Who does a specialty society contact if interested in testifying at the hearing? My email is jgladieux@healthpolicysource.com

5. One approach might be to look to have the quality measure development bodies provide testimony on how best to leverage and guide them to be both a selection committee and development of more cross functional/longitudinal measure/outcomes measures.